Complete Summary

GUIDELINE TITLE

Vertebral subluxation in chiropractic practice.

BIBLIOGRAPHIC SOURCE(S)

Council on Chiropractic Practice. Vertebral subluxation in chiropractic practice. Chandler (AZ): Council on Chiropractic Practice; 2008. 318 p. [2801 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Council on Chiropractic Practice. Vertebral subluxation in chiropractic practice. Chandler (AZ): Council on Chiropractic Practice; 2003. 201 p. (Clinical practice guideline; no. 1). [1100 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Vertebral subluxation

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Chiropractic

INTENDED USERS

Chiropractors

GUIDELINE OBJECTIVE(S)

- To provide the doctor of chiropractic with a "user friendly" compendium of recommendations based upon the best available evidence
- To update the 2003 clinical practice guidelines

TARGET POPULATION

Adults, adolescents, and children who are candidates for chiropractic care

INTERVENTIONS AND PRACTICES CONSIDERED

1. Case history and chiropractic examination
2. Instrumentation
3. Radiographic and other imaging
4. Clinical impression and assessment
5. Reassessment and outcomes assessment
6. Modes of adjustive care
7. Frequency and duration of care
8. Consideration of special needs of children and pregnancy
9. Concerns for patient safety, privacy, and advocacy
10. Continued professional development

MAJOR OUTCOMES CONSIDERED

Detection and correction or stabilization of vertebral subluxation(s)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Literature searches were carried out in 2007-08 by searching Mantis, Medline, and the Cochrane Library. These were supplemented by hand searching the current chiropractic journals, the references listed in key articles and personal collections. The literature was updated until spring 2008.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus
Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Categories of Evidence

E: Expert opinion based on clinical experience, basic science rationale, and/or individual case studies. Where appropriate, this category includes legal opinions.

L: Literature support in the form of reliability and validity studies, observational studies, "pre-post" studies, and/or multiple case studies. Where appropriate, this category includes case law.

C: Controlled studies, including randomized and non-randomized clinical trials of acceptable quality.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The evidence was reviewed by members of the working panels and classified according to the criteria of the US Agency for Health Care Policy and Research.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

This 3rd Edition of Clinical Practice Guidelines "Vertebral Subluxation in Chiropractic Practice" Guidelines were developed by the Council on Chiropractic Practice (CCP) Workgroup between January 2007 and June 2008 (see appendix I of the original guideline document for full membership of the group).

Each individual was sent a structured appraisal form, requesting evidence based comments. Replies were sent to the respondents, and, where appropriate, changes made. Minor changes were also made in the light of new literature

received during the final review process up to the cut-off date of September 1, 2008.

During 2007-08, members of the CCP working group took responsibility for drafting the first version of guidance on specific topics. This synthesis addressed the content and precise wording of the text and recommendations and accuracy of the grading of the evidence. Drafts were circulated within the Group for comment and amendment and editing.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Established. Accepted as appropriate for use in chiropractic practice for the indications and applications stated.

Investigational. Further study is warranted. Evidence is equivocal or insufficient to justify a rating of "established."

Inappropriate. Insufficient favorable evidence exists to support the use of this procedure in chiropractic practice.

COST ANALYSIS

Cost-Effectiveness of Chiropractic Services

Studies suggest that chiropractic, when implemented broadly, would result in significant savings of health care dollars. Substantial health benefits and cost savings to the employer are documented when chiropractic benefits are added to the employee benefits package.

One of the earliest and best estimates of the potential savings with chiropractic comes from a 1996 study by Stano and Smith. Their study compares health insurance payments and patient utilization patterns for episodes of care for common lumbar and low back conditions treated by chiropractic vs. medical providers. Using two years of insurance claims data, this study examines 6,183 patients who had episodes with medical or chiropractic first-contact providers. Multiple regression analysis, to control for differences in patient, clinical, and insurance characteristics, indicates that total insurance payments were substantially greater for episodes with a medical first-contact provider. The mean total payment when chiropractic doctors were the first providers was $518, whereas the mean payment for cases in which a medical doctor (MD) was the first provider was $1,020 (i.e., almost a 50% cost savings when chiropractors are part of the health team).

Several years later, a ground breaking randomized clinical trial (RCT) evaluated the financial impact of provider assignment in the management of neck pain. Patients who saw general practitioners for neck pain were randomly allocated to manual therapy (spinal mobilization), physiotherapy (mainly exercise) or general practitioner care (counseling, education and drugs). Throughout this 52-week study, patients rated their perceived recovery, intensity of pain and functional disability. Manual therapy proved to be the most effective treatment for neck pain. The clinical outcome measures showed that manual therapy resulted in

faster recovery than physiotherapy and general practitioner care. While achieving this superior outcome, the total costs of the manual therapy-treated patients were about one-third the cost of physiotherapy or general practitioner (MD) care.

Refer to the original guideline document for additional review of the literature supporting the cost-effectiveness of chiropractic across the various third-party payers in the United States (Medicare, State Workman's Compensation, private insurance) and internationally.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The draft document was placed on line and representative stakeholders were invited to provide comments/suggestions for revision. These comments were incorporated into the final document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from Council on Chiropractic Practice: This document contains the changes, additions and revisions to the 1998 (1st Edition) and 2003 (2nd Edition) Council on Chiropractic Practice Clinical Guideline. Vertebral Subluxation in Chiropractic Practice. If a recommendation or sub-recommendation was added that was not included in the 1998 or 2003 Guidelines, these are noted. If a recommendation or sub-recommendation remains as it did in the 2003 guidelines, a simple statement that the recommendation remains "unchanged" follows that section/topic.

Definitions of the Recommendation Ratings and Categories of Evidence are provided at the end of the "Major Recommendations" field.

History and Chiropractic Examination

Case History

Recommendation (Unchanged)
A thorough case history should precede the initiation of chiropractic care. The elements of this history should include general information, reason for seeking chiropractic care, onset and duration of any symptomatic problem, family history, past health history, occupational history, and social history.
Rating: Established *Evidence*: E, L

Chiropractic Examination

Recommendation (Unchanged)
The initial chiropractic examination shall include a case history and an assessment for the presence of vertebral subluxation, which, if present, is to be noted with regard to location and character. A review of systems may be conducted at the discretion of the practitioner, consistent with individual training and applicable state laws. Reassessments may be conducted periodically throughout a course of chiropractic care to assess patient progress. Such reassessments typically emphasize re-examination of findings which were positive on the previous examination, although need not be limited to same. Reassessment is also indicated in the case of trauma or change in the clinical status of a patient.
Rating: Established *Evidence*: E, L

Instrumentation

Recommendation (Unchanged)
Instrumentation is indicated for the qualitative and/or quantitative assessment of the biomechanical and physiological components of vertebral subluxation. When using instrumentation, baseline values should be determined prior to the initiation of care.
Rating: Established *Evidence* E, L

Postural Analysis

Sub-Recommendation (Unchanged)
Postural analysis using plumb line devices, computerized and non-computerized instruments may be used to evaluate changes in posture associated with vertebral subluxation.
Rating: Established *Evidence*: E, L

Bilateral and Four-Quadrant Weight Scales

Sub-Recommendation (Unchanged)
Bilateral and four-quadrant weight scales may be used to determine the weight distribution asymmetries indicative of spinal abnormalities.
Rating: Established *Evidence*: E, L

Moiré Contourography

Sub-Recommendation (Unchanged)
Moiré contourography may be used to provide a photographic record of changes in body contour associated with vertebral subluxation.
Rating: Established *Evidence*: E, L

Inclinometry

Sub-Recommendation (Unchanged)
Inclinometry may be used as a means of measuring motion against a constant vertical component of gravity as a reference. Changes in ranges of spinal motion may be associated with vertebral subluxation.
Rating: Established *Evidence*: E, L

Goniometry

Sub-Recommendation (Unchanged)
Goniometry, computer associated or not, may be used to measure joint motion. Inclinometry is superior to goniometry when standardized procedures are employed.
Rating: Established *Evidence*: E, L

Algometry

Sub-Recommendation (Unchanged)
Algometry may be used to measure pressure-pain threshold. Changes in sensory function associated with vertebral subluxation may produce changes in pressure-pain thresholds.
Rating: Established *Evidence*: E, L

Current Perception Threshold (CPT) Testing

Sub-Recommendation (Unchanged)
Current perception threshold devices may be used for the quantitative assessment of sensory nerve function. Alterations in sensory nerve function may be associated with vertebral subluxation.
Rating: Established *Evidence*: E, L

Electroencephalography (EEG)

Sub-Recommendation (Unchanged)
Electroencephalographic techniques, including brain mapping and spectral analysis, may be used to assess the effects of vertebral subluxation and chiropractic adjustment associated with brain function.
Rating: Established *Evidence*: E, L

Somatosensory Evoked Potentials (SSEP)

Sub-Recommendation (Unchanged)
Somatosensory evoked potentials may be used for localizing neurological dysfunction

associated with vertebral subluxations.
Rating: Established *Evidence*: E, L

Skin Temperature Instrumentation

Sub-Recommendation (Unchanged)
Temperature reading devices employing thermocouples, infrared thermometry, or thermography (liquid crystal, telethermography, multiple infrared [IR] detectors, etc.) may be used to detect temperature changes in spinal and paraspinal tissues related to vertebral subluxation.
Rating: Established *Evidence*: E, L

Surface Electromyography

Sub-Recommendation (Unchanged)
Surface electrode electromyography, using hand-held electrodes or affixed electrodes, may be used for recording changes in the electrical activity of muscles associated with vertebral subluxation.
Rating: Established *Evidence*: E, L, C

Muscle Strength Testing

Sub-Recommendation (Unchanged)
Muscle strength testing may be used to determine bilateral differences or other differences in patient resistance. These differences may be characterized by the experienced examiner based on various technologies. Manual, mechanized and computerized muscle testing may be used to determine changes in the strength and other characteristics of muscles. These changes may be a result of alterations of function at various levels of the neuromuscular system and/or any other system related to the patient. Such changes may be associated with vertebral subluxation.
Rating: Established *Evidence*: E, L

Questionnaires

Sub-Recommendation (Unchanged)
Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life throughout a course of chiropractic care. Questionnaires provide important information, but should not be used as a substitute for physical indicators of the presence and character of vertebral subluxations.
Rating: Established *Evidence*: E, L

Heart Rate Variability

Sub-Recommendation (Unchanged)
Heart rate variability may be used to assess autonomic dysfunction associated with vertebral subluxation.
Rating: Established *Evidence*: E, L

Computer Assisted Differential Spinal Compliance

Sub-Recommendation (New)
Computer assisted differential spinal compliance instruments may be used to assess changes in spinal and paraspinal tissue compliance associated with vertebral subluxation.
Rating: Established *Evidence:* E, L

Radiographic and Other Imaging

Recommendation (Unchanged)
Diagnostic imaging procedures may be utilized to characterize the biomechanical manifestations of vertebral subluxation and to determine the presence of conditions which affect the safety and appropriateness of chiropractic care.
Rating: Established *Evidence*: E, L

Plain Film Radiography

Sub-Recommendation (Unchanged)
Plain film radiography is indicated to provide information concerning the structural integrity of the spine, skull, and pelvis; the misalignment component of the vertebral subluxation; the foraminal alteration component of the vertebral subluxation; and the postural status of the spinal column. Imaging procedures, including post-adjustment radiography, should be performed only when clinically necessary. It is common for lines of mensuration to be drawn on radiographs to assess subluxation and alignment. These procedures may be done by hand, or the chiropractor may utilize computerized radiographic digitization procedures.
Rating: Established *Evidence*: E, L

Dosage and Shielding

Sub-Recommendation (Unchanged)
Imaging procedures employing ionizing radiation should be performed consistent with the principles of obtaining films of high quality with minimal radiation. This may include the use of gonad shielding, compensating filters, and appropriate film-screen combinations.
Rating: Established *Evidence*: E, L

Videofluoroscopy

Sub-Recommendation (Unchanged)
Videofluoroscopy may be employed to provide motion views of the spine when abnormal motion patterns are clinically suspected. Videofluoroscopy may be valuable in detecting and characterizing spinal kinesiopathology associated with vertebral subluxation.
Rating: Established *Evidence*: E, L

Magnetic Resonance Imaging (MRI)

Sub-Recommendation (Unchanged)
Magnetic resonance imaging may be employed to assess suspected neoplastic, infectious, and degenerative conditions of the spine and related tissues as well as the stages of subluxation degeneration. Its use is generally restricted to instances where the desired information cannot be obtained by less costly procedures.
Rating: Established *Evidence*: E, L

Computed Tomography (CT)

Sub-Recommendation (Unchanged)
CT imaging may be employed to assess osseous and soft tissue pathology in the spine and contiguous tissues. Its use is generally restricted to instances where the desired information cannot be obtained by less costly procedures.
Rating: Established *Evidence*: E, L

Spinal Ultrasonography

Sub-Recommendation (Unchanged)
Spinal ultrasonography may be used to evaluate the size of the spinal canal (SC) and to detect pathologies in the soft tissues surrounding the spine. Its applications in the assessment of the facet inflammation and nerve root inflammation remain investigational at this time.
Rating: Established for determining spinal canal size. Investigational for facet and nerve root inflammation. *Evidence*: E, L (SC size) E, L (inflammation)

Radioisotope Scanning (Nuclear Medicine Studies)

Sub-Recommendation (Unchanged)
Radioisotope scans performed by qualified medical personnel may be used by a chiropractor to determine the extent and distribution of pathological processes which may affect the safety and appropriateness of chiropractic care when this information cannot be obtained by less invasive means.
Rating: Established *Evidence*: E, L

Radiographic Digitizing Analysis

Sub-Recommendation (Unchanged)
Computerized x-ray analysis may be used by chiropractors to objectively analyze the biomechanical and misalignment improprieties related to vertebral subluxation. Clinical necessity is justified for assessing the degree of insult and the effect upon the patient´s health and future well-being by way of impairment rating.
Rating: Established *Evidence*: E, L

Clinical Impression and Assessment

Recommendation (Unchanged)
Practitioners should develop a method of patient assessment which includes a sufficient diversity of findings to support the clinical impression as related to vertebral subluxation. In this regard, it is considered inappropriate to render an opinion regarding the appropriateness of chiropractic care without a chiropractic assessment, including a physical examination of the patient by a licensed chiropractor. When management of patient care is carried out in the collaborative setting, the chiropractor, as a primary contact health care provider, is the only professional qualified to determine the appropriateness of chiropractic care. The unique role of the chiropractor is separate from other health disciplines, and should be clarified for both the patient and other practitioners. The patient assessment, specific to the technique practiced by the chiropractor, should minimally include a biomechanical and neurophysiological component. It is inappropriate to make a retrospective determination of the clinical need for care rendered prior to the assessment.
Rating: Established *Evidence*: E, L

Record Keeping

Sub-Recommendation (Unchanged)
Since record-keeping practices may be technique/method specific and may depend on the practice objective of the practitioner, chiropractors should develop a method of reporting the care they provide to their patients that is consistent with their practice objectives. Record-keeping systems for practitioners who limit their care to the analysis and correction of vertebral subluxation should minimally reflect the segments/regions adjusted and the techniques or methods employed if they are not self-evident. Other pertinent information may be included on an as-needed basis. **Note**: This Sub-recommendation is in no way meant to contradict other recommendations made in these Guidelines that address issues related to Outcome Assessment, History and Examination, Duration of Care, and Instrumentation.
Rating: Established *Evidence*: E, L

Reassessment and Outcomes Assessment

Recommendation (Unchanged)

Determination of the patient's progress must be made on a per-visit and periodic basis. This process provides quantitative and qualitative information regarding the patient's progress, which is utilized to determine the frequency and duration of chiropractic care. Per-visit reassessment should include at least one analytical procedure previously used. This chosen testing procedure should be performed each time the patient receives chiropractic care. Concomitant with this process, the effectiveness of patient care may also be monitored through the development of an outcomes assessment plan. Such a plan may utilize data from the patient examination, assessment, and reassessment procedures. Patient-reported quality of life instruments, mental health surveys, and general health surveys are encouraged as part of the outcomes assessment plan. The analysis of data from these sources may be used to change or support continuation of a particular regimen of patient care and/or change or continue the operational procedures of the practice.
Rating: Established *Evidence*: E, L

Modes of Adjustive Care

Recommendation (Unchanged)
Adjusting procedures should be selected which are determined by the practitioner to be safe and effective for the individual patient. No mode of care should be used which has been demonstrated by critical scientific study and field experience to be unsafe or ineffective in the correction of vertebral subluxation.
Rating: Established *Evidence*: E, L

Duration of Care for Correction of Vertebral Subluxation

Recommendation (Unchanged)
Since the duration of care for correction of vertebral subluxation is patient specific, frequency of visits should be based upon the reduction and eventual resolution of indicators of vertebral subluxation. Since neither the scientific nor clinical literature provides any compelling evidence that substantiates or correlates any specific time period for the correction of vertebral subluxation, this recommendation has several components which are expressed as follows: a. Based on the variety of assessments utilized in the chiropractic profession, the quantity of indicators may vary, thus affecting the periodicity of their appearance and disappearance, which is tantamount to correction of vertebral subluxation. b. Vertebral subluxation, not being a singular episodic event, such as a strain or sprain, may be corrected but reappear, which necessitates careful monitoring and results in a wide variation in the number of adjustments required to affect a longer-term correction. c. Based on the integrity of the spine in terms of degree and extent of degeneration, the frequency of assessments and the necessity for corrective adjustments, may vary considerably. d. Because the duration of care is being considered relative to the correction of vertebral subluxation, it is independent of clinical manifestations of specific

dysfunctions, diseases, or syndromes. Treatment protocols and duration of care for these conditions are addressed in other guidelines, which may be appropriate for any practitioner whose clinical interests include alleviation of such conditions.
Rating: Established *Evidence*: E, L

Chiropractic Care of Children

Recommendation (Unchanged)
Since vertebral subluxation may affect individuals at any age, chiropractic care may be indicated at any time after birth. As with any age group, however, care must be taken to select adjustment methods most appropriate to the patient's stage of development and overall spinal integrity. Parental education by the subluxation-centered chiropractor concerning the importance of evaluating children for the presence of vertebral subluxation is encouraged.
Rating: Established *Evidence*: E, L

Maternal Chiropractic Care

Recommendation (Unchanged)
In pregnancy a woman's body experiences numerous biomechanical adaptations and physiological changes. These changes often have an adverse affect on her neuro-musculo-skeletal system affecting quality of life in pregnancy, birth outcome, and the future well-being of her baby. Because of these physiological compensations, practitioner care must be taken to select the specific analysis and adjustment most appropriate for the complex changes throughout the various stages of pregnancy. The increased potentials for spinal instability in the mother and the resulting subluxations in the woman's spine throughout pregnancy affect the health and well-being of both her and her baby. This warrants regular chiropractic check-ups in all women throughout pregnancy. Patient education pertinent to chiropractic care in pregnancy is encouraged.
Rating: Established *Evidence*: E, L

Subluxation and Well-Being

Recommendation (New)
"Doctors of Chiropractic advise and educate patients and communities in structural and spinal hygiene and healthful living practices." (Association of Chiropractic Colleges, 2009) "Doctors of Chiropractic establish a doctor/patient relationship and utilize adjustive and other clinical procedures unique to the chiropractic discipline. Doctors of Chiropractic may also use other conservative patient care procedures, and, when appropriate, collaborate with and/or refer to other health care providers." (Association of Chiropractic Colleges, 2009)
Rating: Established

Evidence: E, L

Behavioral and Mental Health Issues

Recommendation (New)
Chiropractic is not a treatment for specific behavioral or mental health conditions. However, chiropractic care is established as a clinical strategy that may improve the clinical strategy that may improve the clinical status of persons with general health issues and certain behavioral or mental health conditions.
Rating: Established *Evidence*: E, L

Patient Safety, Privacy, and Advocacy

Patient Safety

Recommendation (Unchanged)
Patient safety encompasses the entire spectrum of care offered by the chiropractor. Consequently, it is important to define at the onset, the nature of the practice as well as the limits of care to be offered. Minimally this should include a "Terms of Acceptance" document between the practitioner and the patient. Additionally, all aspects of clinical practice should be carefully chosen to offer the patient the greatest advantage with the minimum of risk.
Rating: Established *Evidence*: E, L

Patient Privacy

Recommendation (Unchanged)
Respecting patients' right of privacy has always been both an ethical and a legal duty. New federal regulations place specific, enforceable obligations on most chiropractors and their employees. Knowledge of and compliance with these regulations is essential in order to remain in practice.
Rating: Established *Evidence*: E, L

Patient Advocacy

Recommendation (New)
Patient advocacy is an important part of advancing safety, efficacy, and utilization of chiropractic services. Effective patient advocacy programs promote quality, safety, appropriateness of service, support patient choice of adjustive care, and appropriateness of referrals inside and outside the profession.
Rating: Established *Evidence*: E, L

Professional Development

Recommendation (Unchanged)

The science, art, and philosophy of chiropractic, and hence its practice, continues to expand in understanding and development. Continuing professional development, as in all responsible health professions, is a necessary component of maintaining a high standard for both the practitioner and the profession. Continuing development should be directed to areas germane to each individual practice, including, but not limited to, credentialing, continuing education programs, participation in professional organizations, technique protocols and application, radiographic and other imaging, instrumentation, philosophy, research, practice liability issues, legal issues, and ethics. Since all state licensing jurisdictions are ultimately responsible for patient health and safety, these guidelines recommend that all subjects congruent with state law be considered appropriate for continuing education credits in respective states.
Rating: Established *Evidence*: E, L

Definitions:

Recommendation Ratings

Established. Accepted as appropriate for use in chiropractic practice for the indications and applications stated.

Investigational. Further study is warranted. Evidence is equivocal or insufficient to justify a rating of "established."

Inappropriate. Insufficient favorable evidence exists to support the use of this procedure in chiropractic practice.

Categories of Evidence

E: Expert opinion based on clinical experience, basic science rationale, and/or individual case studies. Where appropriate, this category includes legal opinions.

L: Literature support in the form of reliability and validity studies, observational studies, "pre-post" studies, and/or multiple case studies. Where appropriate, this category includes case law.

C: Controlled studies, including randomized and non-randomized clinical trials of acceptable quality.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified with each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Improved chiropractic care reflected in accurate identification and correction of vertebral subluxation

POTENTIAL HARMS

Considerable visibility and public scrutiny surrounds possible risks associated with Spinal Adjustment and Manipulation. Non-serious side effects are relatively common and may consist of localized discomfort, headache, or fatigue that resolves within 24 to 48 hours. The concern raised by scientific and popular media reports in the United States and Canada are that chiropractic "manipulation" of the cervical spine is associated with stroke. However, solid scientific evidence of a causal relationship between such adverse events and the "manipulation" is lacking.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The purpose of these guidelines is to provide the doctor of chiropractic with a "user friendly" compendium of recommendations based upon the best available evidence. It is designed to facilitate, not replace, clinical judgment.
- The most compelling reason for creating, disseminating, and utilizing clinical practice guidelines is to improve the quality of health care. The recommendations made in this guideline are specific to the clinical entity of vertebral subluxation and are applicable to the stated goals of the guideline. The recommendations are meant to be flexible, based upon each patient encounter and the goals of both the practitioner and the patient being cared for.
- These guidelines are for informational purposes. Utilization of these guidelines is voluntary. They are not intended to replace the clinical judgment of the chiropractor. It is acknowledged that alternative practices are possible and may be preferable under certain clinical conditions. The appropriateness of a given procedure must be determined by the judgment of the practitioner and the needs and preferences of the individual patient.
- It is not the purpose or intent of these guidelines to provide legal advice, or to supplant any statutes, rules, and regulations of a government body having jurisdiction over the practice of chiropractic.
- These guidelines address vertebral subluxation in chiropractic practice and do not purport to include all procedures which are permitted by law in the practice of chiropractic. Lack of inclusion of a procedure in these guidelines does not necessarily mean that the procedure is inappropriate for use in the practice of chiropractic.

- Participation in the guidelines development process does not necessarily imply agreement with the final product. This includes persons who participated in the technique conference, leadership conference, open forum, and peer review process. Listing of names acknowledges participation only, not necessarily approval or endorsement. The guidelines reflect the consensus of the panel, which gave final approval to the recommendations.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

This document will be disseminated to all stakeholders. It will also be available on CD ROM and hosted on the Website of the Council on Chiropractic Practice (www.ccp-guidelines.org) for downloading.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Council on Chiropractic Practice. Vertebral subluxation in chiropractic practice. Chandler (AZ): Council on Chiropractic Practice; 2008. 318 p. [2801 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1998 (revised 2008)

GUIDELINE DEVELOPER(S)

Council on Chiropractic Practice - Private Nonprofit Organization

SOURCE(S) OF FUNDING

Council on Chiropractic Practice

GUIDELINE COMMITTEE

Council on Chiropractic Practice Guideline Panel

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Council on Chiropractic Practice (CCP) 2008 Revision & Update: Robert H. Blanks PhD, Professor of Cell Biology and Anatomy, University of Miami Miller School of Medicine, Miami, FL; Christopher Kent DC, FCCI, JD, President, Council on Chiropractic Practice, Ramsey, NJ; Matthew McCoy BS, DC, Associate Professor Clinical Sciences, Life University College of Chiropractic, Marietta, GA, Editor, Journal of Vertebral Subluxation Research; Karen Numeroff, DC, Director of Clinical Testing and Remediation, Life University College of Chiropractic, Marietta, GA; Anquonette Stiles, B.S., Research Assistant, Life University College of Chiropractic, Marietta, GA

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Council on Chiropractic Practice. Vertebral subluxation in chiropractic practice. Chandler (AZ): Council on Chiropractic Practice; 2003. 201 p. (Clinical practice guideline; no. 1). [1100 references]

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Council on Chiropractic Practice Web site.

Print copies: Available from the Council on Chiropractic Practice, 2950 N. Dobson Road, Suite 1, Chandler, AZ 85224; (800) 347-1011.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on November 1, 1998. The information was verified by the guideline developer on January 5, 1999. This summary was updated by ECRI on June 11, 2004. The information was verified by the guideline

developer on July 8, 2004. This NGC summary was updated by ECRI Institute on April 24, 2009.

COPYRIGHT STATEMENT

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Copyright/Permission Requests

Date Modified: 7/27/2009


DEPARTMENT OF HEALTH & HUMAN SERVICES • USA